Maximum Allowable Fee Schedule for Dental Services in the BadgerCare Plus Benchmark Plan

Wisconsin Medicaid-certified providers will be reimbursed the rates listed on this schedule for covered services provided to eligible members.

Note: Effective February 1, 2008, BadgerCare Plus Benchmark Plan members will have different maximum allowable fees and different covered benefits than BadgerCare Plus Standard Plan members. Covered services for BadgerCare Benchmark Plan members are limited to diagnostic, preventative, simple restorative and Temporo-Mandibular Joint (TMJ) procedures. There is an annual limit of $750.00 reimbursement for each member. BadgerCare Plus Benchmark Plan members will be responsible for a $200.00 deductible per enrollment year, except for preventative and diagnostic services. This schedule provides the maximum allowable fee for BadgerCare Plus Benchmark Plan members. To view maximum allowable fees for Standard Plan members, please go to the Dental Maximum Allowable Fee Schedule.

This maximum allowable fee schedule for BadgerCare Plus Benchmark members contains the following information:

Procedure Code	The procedure code recognized by BadgerCare Plus to identify the service provided.
Procedure Description	An abbreviated description of the procedure code.
Provider Type	All applicable performing provider types for the procedure code.
Max Fee Effective 1/1/2008	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA) for dates of service on or after 1/1/2008.
Max Fee Effective 7/1/08	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA) for dates of service on or after 7/1/2008.

The fee schedule does not address the various coverage limitations routinely applied by BadgerCare Plus before final payment is determined (e.g., member and provider eligibility, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fee schedule, providers should contact Provider Services at (800) 947-9627.
For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst
Division of Health Care Access and Accountability (DHCAA)
Dental Services
PO Box 309
Madison WI 53701-0309

Procedure Code	Procedure Description	Provider Type	Max Fee Effective 1/1/2008 – 6/30/2008	Max Fee Effective 7/1/2008
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	27	$32.00	$32.32
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	27	$47.00	$47.47
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	27	$50.00	$50.50
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION	27	$65.00	$65.65
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	27	$38.00	$38.38
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	27	$90.00	$90.90
D0220	INTRAORAL-FIRST PERIAPICAL FILM	27	$19.00	$19.19
D0230	INTRAORAL-EA ADD'L PERIAPICAL FILM	27	$15.00	$15.15
D0240	INTRAORAL- OCCLUSAL FILM	27	$25.00	$25.25
D0250	EXTRAORAL-FIRST FILM	27	$30.00	$30.30
D0260	EXTRAORAL-EACH ADD'L FILM	27	Manually Priced	Manually Priced
D0270	BITEWINGS-SINGLE FILM	27	$20.00	$20.20
D0272	BITEWINGS-TWO FILMS	27	$30.00	$30.30
D0273	BITEWINGS-THREE FILMS	27	$36.00	$36.36
D0274	BITEWINGS- FOUR FILMS	27	$42.00	$42.42
D0330	PANORAMIC FILM	27	$82.00	$82.82

Procedure Code	Procedure Description	Provider Type	Max Fee Effective 1/1/2008 – 6/30/2008	Max Fee Effective 7/1/2008
D0340	CEPHALOMETRIC FILM	27	$80.00	$80.80
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	27	$35.00	$35.35
D0470	DIAGNOSTIC CASTS	27	$66.00	$66.66
D0486	ACCESSION OF BRUSH BIOPSY SAMPLE,MICROSCOPIC EXAM, PREP & TRANSMISSION OF WRITTEN REPORT	27	$175.00	$176.75
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURES, BY REPORT	27	$38.00	$38.38
D1110	PROPHYLAXIS-ADULT/13-99	27	$60.00	$60.60
D1120	PROPHYLAXIS-CHILD/00-12	27	$45.00	$45.45
D1203	TOP FLUORIDE - CHILD/00-12 (EXCLUDING PROPHYLAXIS	27	$26.00	$26.26
D1204	TOP FLUORIDE-ADULT/13-99 (EXCLUDING PROPHYLAXIS)	27	$27.00	$27.27
D1206	TOPICAL FLUORIDE VARNISH;THERAPUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENT	27	$27.00	$27.27
D1351	SEALANT, PER TOOTH	27	$35.00	$35.35
D1510	SPACE MAINTAIN-FIXED UNILATERAL	27	$210.00	$210.10
D1515	SPACE MAINTAIN-FIXED-BILATERAL	27	$300.00	$303.00
D1550	RECEMENT SPACE MAINTAINER	27	$46.00	$46.46
D1555	REMOVAL OF FIXED SPACE MAINTAINER	27	$25.00	$25.25
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	27	$85.00	$85.85

Procedure Code	Procedure Description	Provider Type	Max Fee Effective 1/1/2008 – 6/30/2008	Max Fee Effective 7/1/2008
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	27	$103.00	$104.03
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	27	$125.00	$126.25
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	27	$150.00	$151.50
D2330	RESIN-1 SURFACE, ANTERIOR	27	$100.00	$101.00
D2331	RESIN-2 SURFACES, ANTERIOR	27	$125.00	$126.25
D2332	RESIN-3 SURFACES, ANTERIOR	27	$151.00	$152.51
D2335	RESIN, INVOLVE INCISAL ANGLE, ANTERIOR, 4 OR MORE SURFACES	27	$184.00	$185.84
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	27	$250.00	$252.50
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	27	$111.00	$112.11
D2392	RESIN-BASED COMPOSITE-TWO-SURFACES, POSTERIOR	27	$145.00	$146.45
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	27	$175.00	$176.75
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	27	$204.00	$206.04
D4210	GINGIVECTOMY OR GINGIVOPLASTY-4 OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES,PER QDT	27	$400.00	$404.00
D4211	GINGIVECTOMY OR GINGIVOPLASTY-1 TO 3 CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUAD	27	$151.00	$152.51

Procedure Code	Procedure Description	Provider Type	Max Fee Effective 1/1/2008 – 6/30/2008	Max Fee Effective 7/1/2008
D4341	PERIODONTAL SCALING & ROOT PLANING-4 OR MORE TEETH PER QUADRANT	27	$175.00	$176.75
D4342	PERIODONTAL SCALING AND ROOT PLANING-ONE TO THREE TEETH, PER QUADRANT	27	$105.00	$106.05
D4355	FULL-MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	27	$123.00	$124.23
D4910	PERIODONTAL MAINTENANCE	27	$95.00	$95.95
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	27	$100.00	$101.00

TMJ Procedures				
Procedure Code	**Procedure Description**	**Provider Type**	**Max Fee Effective 1/1/2008 – 6/30/2008**	**Max Fee Effective 7/1/2008**
D7810	TMJ-OPEN RDN OF DISLOCATION	27	Manually Priced	Manually Priced
D7820	TMJ-CLOSED RDN OF DISLOCATION	27	$486.00	$490.86
D7830	TMJ MANIP UNDER ANESTHESIA	27	$339.00	$342.39
D7840	CONDYLECTOMY	27	Manually Priced	Manually Priced
D7850	SURG DISCECTOMY W/WOUT IMPLANT	27	Manually Priced	Manually Priced
D7860	ARTHROTOMY, TMJ	27	$4,058.00	$4,098.58
D7865	ARTHROPLASTY	27	Manually Priced	Manually Priced
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	27	$766.00	$773.66
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	27	Manually Priced	Manually Priced
20605	ARTHROCENTESIS, ASPIRATION/INJECTION, INTERMEDIATE JOINT/BURSA (E.G. WRIST, ELBOW)	27	$82.00	$82.82
21050	SONDYLECTOMY, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)	27	Manually Priced	Manually Priced
21060	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)	27	Manually Priced	Manually Priced
21070	CORONOIDECTOMY (SEPARATE PROCEDURE)	27	$2,565.00	$2,590.65

TMJ Procedures continued				
Procedure Code	**Procedure Description**	**Provider Type**	**Max Fee Effective 1/1/2008 – 6/30/2008**	**Max Fee Effective 7/1/2008**
21240	ARTHROPLASTY,TEMPOROMANDIBULAR JOINT,WITH OR WITHOUT AUTOGRAFT (INCLUDES OBTAINING GRAFT	27	Manually Priced	Manually Priced
21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT	27	Manually Priced	Manually Priced
21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT	27	$6,567.00	$6,632.67
21480	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; INITIAL OR SUBSEQUENT	27	$369.00	$372.69
21485	COMPLICATED (EG, RECURRENT REQUIRING INTERMAXILLARY FIXATION OR SPLINTING),INITIAL OR	27	Manually Priced	Manually Priced
21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION	27	Manually Priced	Manually Priced
29800	ARTHROSCOPY,TEMPOROMANDIBULAR JOINT,DIAGNOSTIC,WITH OR WITHOUT SYNOVIAL BIOPSY	27	Manually Priced	Manually Priced
29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL	27	$3,530.00	$3,565.30